Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Alta Vista Healthcare
5445 La Sierra Dr. #204
Dallas, Texas 75231

Sent
OCT 11 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

MFDR Tracking #: M4-07-3084-01

Respondent Name and Box #:

American Protection Insurance
Rep Box #: 21

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The claims were denied and per EOB, the services are not deemed medically necessary. The medical necessity of the services were affirmed when the preauthorization was approved, #1656593."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $3468.75
3. CMS 1500s
4. EOBs
5. Copy of Preauthorization Letter

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: None Provided

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
02/13/06	97799-CP-CA	1st EOB W1,45,147,50 2nd EOB 97,147,50	1, 2, 3	$718.75
02/14/06	97799-CP-CA	1st EOB W1,45,147,50 2nd EOB 97,50	1, 2, 4	$750.00
02/15/06	97799-CP-CA	1st EOB W1,45,147,50 2nd EOB 97,50	1, 2, 5	$1000.00
02/16/06	97799-CP-CA	1st EOB W1,45,147,50 2nd EOB W1,45,50	1, 2, 6	$1000.00
Total Due:				$3468.75

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

Requestor has provided Updated Table of Disputed Services correcting DOS on original Table to match the CMS and EOBs submitted for dispute.

1. CPT code 97799 CP-CA on DOS 02/13, 02/14, 02/15, and 02/16 of 2006 were denied by the Respondent with reason codes "97, 50, 45, W1, and 147" listed on EOB with the same denial explanation "These are non-covered services because this is not deemed a "medical necessity" by the payer."
2. A denial of medical necessity is not valid as necessity has been established by Preauthorization #1656593 dated 02/02/06 covering the period from 02/02/06 through 03/02/06 for 5 days of Chronic Pain Management. Per Rule 133.301(a), the Respondent shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization. Therefore, reimbursement is due Requestor.
3. CPT Code 97799 CP-CA is reimbursable at a rate of $125/hr for CARF accredited facilities. Documentation shows 5.75 hours billed for DOS 02/13/06. Reimbursement due is $718.75 to Requestor per Rule 134.202(e)(5)(E).
4. CPT Code 97799 CP-CA is reimbursable at a rate $125/hr for CARF accredited facilities. Documentation shows 6.00 hours billed for DOS 02/14/06. Reimbursement due is $750.00 to Requestor per Rule 134.202(e)(5)(E).
5. CPT Code 97799 CP-CA is reimbursable at a rate of $125/hr for CARF accredited facilities. Documentation shows 8.00 hours billed for DOS 02/15/06. Reimbursement due is $1,000.00 to Requestor per Rule 134.202(e)(5)(E).
6. CPT Code 97799 CP-CA is reimbursable at a rate of $125/hr for CARF accredited facilities. Documentation shows 8.00 hours billed for DOS 02/16/06. Reimbursement due is $1,000.00 to Requestor per Rule 134.202(e)(5)(E).

A referral to Legal & Enforcement has been made.

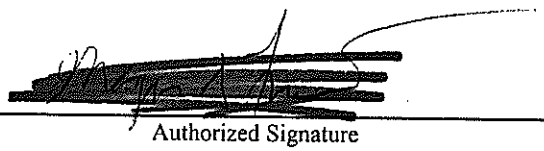
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202, Section 134.600
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $3468.75 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER



Authorized Signature

[redacted]
Medical Fee Dispute Resolution Officer

10/11/07
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.